

plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (f), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year (except that for purposes of this paragraph, a small employer shall include an employer with one employee in the case of an employer residing in a State that permits small groups to include a single individual). See also section 2721(a) of the PHS Act and § 146.145(b) of this Part, which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(g) *Increased cost exemption* [Reserved]

(h) *Sale of nonparity health insurance coverage.* A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the

plan meets the requirements of paragraph (f) or (g) of this section.

(i) *Applicability dates*—(1) *In general.* Except as provided in paragraph (i)(2) of this section, the requirements of this section are applicable for plan years beginning on or after July 1, 2010.

(2) *Special effective date for certain collectively-bargained plans.* For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the later of either—

(i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or

(ii) July 1, 2010.

[75 FR 5444, Feb. 2, 2010]

Subpart D—Preemption and Special Rules

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of ERISA with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health

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insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act which differs from the standards or requirements specified in section 2701 of the PHS Act.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the “6-month period” described in section 2701(a)(1) of the PHS Act and §146.111(a)(2)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the “12 months” and “18 months” described in section 2701(a)(2) of the PHS Act and §146.111(a)(2)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the “63-day period” described in sections 2701(c)(2)(A) and (d)(4)(A) of the PHS Act and §§146.111(a)(2)(iii) and 146.113 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the “30-day period” described in sections 2701(b)(2) and (d)(1) of the PHS Act and §146.111(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) of the PHS Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 2701(f) of the PHS Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B) of the PHS Act.

(d) *Definitions*—(1) *State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to

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the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in §144.103), any political subdivisions of a State, or any agency or instrumentality of either.

[69 FR 78797, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005]

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Definition.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than §146.130 and the provisions with respect to genetic non-discrimination (found in §146.111(b)(6), §146.121(b), §146.121(c), §146.121(e), §146.122(b), §146.122(c), §146.122(d), and §146.122(e)) do not apply to any group health plan (and group health insurance coverage) for any plan year, if on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;